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Reaching consensus on the definition of person-centred handover practices in emergency departments: A modified online Delphi

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Abstract

Aim: To reach consensus on the definition and attributes of 'person-centred handover practices' in emergency departments.

Background: Handover practices between emergency care practitioners and healthcare professionals in emergency departments are important and should be conducted meticulously. Person-centred handover practices may enhance the delivery of person-centred care in emergency departments.

Design: A three-round online Delphi survey.

Methods: Nine experts participated in a three round Delphi survey. The expert panel comprised experts from nine countries. Quantitative data were descriptively analysed, and qualitative data were thematically analysed. A consensus of 80% had to be reached before an attribute and definition could be accepted.

Results: Experts reached a consensus of 79% in round one, 95% in round two and 95% in round three. A final set of six attributes were agreed upon and the final concept definition was formulated.

Conclusion: Person-centred handover practices have not been implemented in emergency departments. Yet, person-centred handover practices may enhance the delivery of person-centred care, which has multiple benefits for patients and healthcare practitioners.

Implications for the profession and/or patient care: Person-centred care is not generally implemented in emergency departments. Person-centred handover practices can lead to person-centred care. Handover practices in emergency departments are a high-risk activity. Despite numerous calls to standardise and improve handover practices, they remain a problem. Developing a standardised definition could be a first step towards implementing person-centred handover practices in emergency departments.

Reporting method: The study adhered to the relevant EQUATOR reporting guidelines: Guidance on Conducting and Reporting Delphi Studies (CREDES) checklist.

Impact (Addressing):

- Improve handover practices and patient care.
- Improve person-centred care in emergency departments.

Patient or public contribution: Emergency care practitioners and nurses experienced in handover practices and/or person-centred care, working in clinical and academic fields, participated in the study by sharing their expert knowledge during each of the Delphi rounds.

KEYWORDS
concept, Delphi, emergency department, handover practices, person-centred care

What does this paper contribute to the wider global community?

- This is the first study to define person-centred handover practices and related attributes.
- Experts agreed that there is a need to define person-centred handover practices.
- This research will ultimately benefit emergency care practitioners, healthcare professionals, and patients in emergency departments.
- This study opens up avenues for future debate as this definition is the first and will most probably be updated in the future as the importance of the concept is recognised more widely.

1 | INTRODUCTION

In emergency departments (EDs), handovers or handoffs are an integral daily activity for every healthcare provider. Handover is defined as the transfer of accountability and responsibility from one healthcare provider to the next (Cheetham et al., 2023; Guasconi et al., 2022). Handovers are important for continuity of patient care from emergency care practitioners (pre-hospital) to medical doctors and/or nurses in EDs (in-hospital) (Cheetham et al., 2023). Emergency care practitioners often only have one opportunity to transfer information to healthcare professionals, and information should be transferred optimally (Makkink et al., 2021). Much research has focussed on improving handover practices, but little attention has been given to the involvement of patients and/or significant others in the process (Tortosa-Alted et al., 2021). Recently, much effort has been directed at moving towards person-centred care delivery in healthcare, nursing, and EDs (Nicholas et al., 2020). Person-centred handover practices that include patients and/or significant others may promote the delivery of person-centred care (White-Trevino & Dearmon, 2018). Person-centred handover involves the handover of patient information between healthcare professionals together with the patient whilst performing the handover according to a set structure focussing on relevant clinical information and patient safety concerns (Chien et al., 2022; Kullberg et al., 2017). Furthermore, person-centred handover involves more than just the transfer of information, it should be a process were both parts gain new insights (Kullberg et al., 2018). Person-centred handover practices have been shown to gradually increase patient and staff satisfaction, enhanced quality care and patient safety (Chien et al., 2022). Although person-centred handover practices are advocated for and preferred by patients, in many instances this does not happen (Kerr et al., 2013; Oxelmark et al., 2020). Person-centred handover in nursing is novel, and most nurses were not trained or adequately trained to perform this during their education. Nurses also struggle to share information whilst inviting patients to partake on the handover (Kullberg et al., 2018). In the ED the handover between emergency care practitioners and healthcare professionals in EDs should involve respect for everyone and the patient to enhance patient safety (Dúason et al., 2021) and move towards person-centred handover practices. At the time no literature could be found on the performing of person-centred handover practices amongst doctors or emergency care practitioners. Here, we report on a Delphi study that aimed to define and identify the attributes of 'Person-centred handover practices' in EDs. An accepted definition for person-centred handover practices may advance such handover practices leading to the delivery of person-centred care in EDs.

2 | BACKGROUND

EDs are busy, somewhat chaotic environments where many events occur simultaneously and often against the clock (Najafi Kalyani et al., 2017). In EDs, clinical skills and saving lives are often emphasised, while handovers are often neglected (Campbell & Dontje, 2019). In EDs, handovers between emergency care practitioners and healthcare professionals differs from handovers done in other healthcare environments (Sanjuan-Quiles et al., 2018). Handovers involve different healthcare professionals, patients, and/or significant others sharing verbal, non-verbal, and written information (Crouch et al., 2021; Dúason et al., 2021). Structured guides have been suggested for sharing information on patients' complaints,

previous treatment and condition (Bagnasco et al., 2019; Guasconi et al., 2022), but structured handover is not a one size fits all as it does not consider the context of the patient and the ED (Makkink et al., 2019; Shapiro, 2019).

Person-centred care involves placing patients at the centre of care delivery. Although person-centred care has been adopted in various healthcare settings, it has not been widely integrated in EDs (McConnell et al., 2016; Walsh et al., 2022). Person-centred care encompasses communication, involving patients and families in information sharing and decision making, and ensuring continuity and transition of care (Walsh et al., 2022). This approach informs patients, reduces emotional distress and uncertainty, and encourages their active involvement in their own care as experts, fostering collaboration between patients and providers (Walsh et al., 2022). Despite the benefits, there is no accepted definition or implementation framework for person-centred care in EDs (Walsh et al., 2022). Walsh et al. (2022) proposed that operationalising person-centred care in EDs would lead to person-centred practices in the ED. As handover practices are an integral element of care in EDs, patients should be included in the handover process (Kullberg et al., 2017), as they are the only constant during handovers and are vital for ensuring continuity of care (Merten et al., 2017). To initiate the advancement of person-centred practices in EDs, we conducted a concept analysis to develop a preliminary definition for person-centred handover practices in EDs. Here, we expanded on the concept analysis by engaging with experts to reach consensus on the definition and identify attributes of person-centred handover practices in EDs.

3 | THE STUDY

3.1 | Ethical approval

Ethical approval for the Delphi study was obtained from the University of Pretoria's ethics committee. Each participant received a participant information leaflet and signed an informed consent form before data were collected.

4 | METHODS

The Delphi survey was conducted in three phases as suggested by Beiderbeck et al. (2021). First, we clarified the aim of the study, selected expert panel members, defined the criteria for consensus, and developed a questionnaire for round one. Second, participants completed the questionnaire. Third, we analysed the responses from each round to determine agreement and conducted a content analysis.

4.1 | Aim

To determine the level of agreement on the definition and attributes of person-centred handover practices in EDs. We presented a provisional definition of the concept and listed attributes that were constructed using Walker and Avant (2014) model for concept analysis in a previous study (still to be published). We conducted a concept analysis following the eight steps (Walker & Avant, 2014) which led to six constructed attributes which was subsequently used to develop the concept definition. These six attributes and the developed concept definition was used during this study to reach consensus on the definition and attributes of person-centred handover practices in EDs.

4.2 | Design

A three-round online modified Delphi survey was conducted between 28 January 2023 and 16 May 2023. Delphi surveys are widely used to reach consensus (Jünger et al., 2017) and provide insight on topics with limited information (Beiderbeck et al., 2021). The number of rounds may vary from two to five (Jünger et al., 2017), and the list of items and participants may vary for each round. Subsequent rounds were designed based on responses from the previous round (Jünger et al., 2017).

4.3 | Participants

There is no fixed rule for how many experts should be included in panels but a minimum of between 10 and 18 experts has been suggested (Santaguida et al., 2018). Beiderbeck et al. (2021) suggest that smaller groups of experts should be used to reach consensus on specialised topics, such as those in clinical fields, optimally between 15 and 20 experts. We invited 17 experts from 10 countries to participate. Experts were identified via a literature search, through research team members, networking, and through suggestions from invited experts. All invited experts had extensive knowledge on person-centred care, handover practices, or both, and met the following inclusion criteria: a clinician providing person-centred care and involved in handover practices (all participants had more than 10 years' experience in person-centred care and handover practices), authors on publications of person-centred care (all participants had at least two publications in the last 5 years), involved in academia (two participants had masters degrees, and the rest had doctoral degrees, with at least 4 years' and a maximum of 32 years' experience in academia and clinical settings as nurses and emergency care practitioners).

4.4 | Data collection

During round one, the constructed concept definition and related attributes were distributed electronically to participants who were asked to respond within 2 weeks. We sent a reminder email to participants who had not responded 1 week before the deadline. The initial questionnaire included six attributes and the concept definition.

Participants were asked to rate their agreement with each attribute and the concept definition on a 4-point Likert scale (1: strongly disagree to 4: strongly agree) and had the opportunity to provide additional written comments and the reason for their ranking. Responses were anonymised after each round before sending feedback to the group. After each round, the attributes and definition were adjusted based on participants' feedback and sent back to the participants for the next round. After the third round, a summary of the final attributes and definition were circulated to the participants for final review and agreement.

4.5 | Data analysis

Data were analysed using percentage agreement for each question. Consensus was defined as 80% agreement, when 80% of the participants indicated strong agreement (3 or higher on the Likert-scale). This was a more stringent level of agreement than the 75% suggested by Diamond et al. (2014). Data from each round were analysed by three members in the research team, the attributes and definition adjusted, and returned to the participants for the next round, together with a report on the previous round's results and level of agreement. Comments were analysed through content analysis focussing on recurring patterns or themes (Elo & Kyngäs, 2008). Content analysis was done to identify words, themes, or concepts in the data. One member of the research team analysed each comment and recurrent words identified. From there themes were created based on the combination of repetitive words identified. Data was then read again to confirm the developed themes. Final themes were then checked and correlated to confirm correctness by the other two members of the research team.

4.6 | Rigour

Maintaining rigour in Delphi studies is critically important. Delphi studies require methodological accuracy to avoid pitfalls such as prolonged data collection, low response rates, subjective data analysis and unsuitable statements. Our study had a brief timeline of 15 weeks, and experts were carefully selected according to specific criteria from different countries. Participants were regularly reminded to meet deadlines. To increase rigour, one team member analysed the data and two members then checked the results. Electronic audit trails were kept of all the data. Responses of each round were individually and anonymously shared via email with the panel of experts. Additionally, we conducted our study in line with the checklist for Conducting and REporting DElphi Studies (CREDES) (Jünger et al., 2017), which improved the planning and design, execution, and reporting of the study (Guidelines for Conducting and REporting DElphi Studies [CREDES]), (Data S1).

5 | RESULTS

5.1 | Participants

Of the 17 participants who were invited to participate; nine consented to participate. Nine participants completed round one (53%), eight completed round two (47%) and eight completed round three (47%). Participants from three countries responded and their experienced ranged from doctoral ($n=7$) to masters ($n=2$) degrees with between 4- and 32-years' experience in academia and clinical settings. All participants were experts in the field of person-centred care and/or handover practices. Seven participants worked permanently in academia with two participants working in clinical settings but involved in academic activities (Table 1).

5.2 | Attributes of person-centred handover practice

Attributes are those aspects specific to the concept and sets it apart from other (Kemp, 1985). Experts evaluated six attributes of person-centred handover practices. In round one, agreement ranged from 56% to 89% on the various attributes (Table 2). Agreement increased in round two, ranging from 86% to 100% (Table 2). Despite strong agreement, participants made valuable comments, and the attributes were adjusted accordingly. In round three, participants reached final consensuses and no additional feedback was received.

5.2.1 | Attribute 1: Structure

Theme 1: Importance of structure

In round one, more than half of participants (56%) felt that handovers should be structured to some degree. Participants indicated that structure prevents information loss, 'it will minimize lost information that could be skipped if no structure is followed' and '…ensure nothing is missed'. Conversely, participants indicated that following a set structure could also lead to information loss, '… information not included in the structure (for example a mnemonic) may be omitted'.

Theme 2: Suitable to context

The idea of a structured approach was adapted in rounds two and three. Although structured handover practices were deemed important, they should be '…suited to the context'. Additionally, the context should also be tailored to the needs of the patient, 'specific structures do not cater for the patient-specific information that that may be more or less important between patients' and 'that the structure take into account aspects of holistic care'.

Participants agreed that handovers should be context specific as one structure may not apply to all handovers. Following a context specific approach has benefits, 'individualisation is needed to ensure all relevant information', 'enhances systematic and focused

TABLE 1 Participant characteristics.

Participant	Country	Qualification	Experience	Current role
Participant 1	Australia	PhD	>30 years academia >20 years person-centred care and handover	Academia—nursing and person-centred care
Participant 2	UK	PhD	>20 years person-centred care experience and academia	Academia—nursing and person-centred care
Participant 3	South Africa	Master's degree	>20 years person-centred care and handover >4 years academia	Clinical nursing education
Participant 4	South Africa	Master's degree	>30 years person-centred care and handover	Nursing management
Participant 5	South Africa	PhD	>20 years handover and academic experience in person-centred handover	Academia and clinical education emergency care practitioners
Participant 6	South Africa	PhD	>10 years clinical >4 years person-centred care	Academia—nursing education
Participant 7	UK	PhD	>10 years academic and person-centred care	Academia—person-centred care
Participant 8	South Africa	PhD	>20 years' experience in academia and >15 years in person-centred care	Academia—nursing education
Participant 9	Australia	PhD	>10 years academic >20 years clinical experience in person-centred care and handover	Academia—nursing

decision-making' and 'although structure is important it alone cannot ensure that all info will always be transferred'.

5.2.2 | Attribute 2: Verbal and written information transfer

Theme 1: Concurrent processes

In round one, more than half of participants (56%) indicated that handover involves the simultaneous transfer of verbal and written information. Verbal and written information transfer 'should occur concurrently to ensure they are consistent with each other'. Simultaneous transfer of verbal and written information prevents the loss of information, and there are more opportunities for asking clarifying questions. Participants 'strongly agree that effective communication practices should be used'.

Theme 2: Verbal and written information should be complementary

According to participants in round one, verbal information is, 'a summary of the information', 'is quick', and 'provides opportunity to ask questions'. Written information allows for, 'fine detail is not lost', 'comprehensive patient information', and 'verifies information'. However, 'handover, both verbal and written should incorporate person-centred principles'. Participants agreed that both verbal and written components are an important part of handovers, 'both important components of sharing information'.

In rounds two and three, this attribute was adjusted to include non-verbal communication. Non-verbal communication should be included and recorded in handovers for additional benefits, 'effective communication practices should include verbal, written and visual communication', 'covering all 3 of those communication aspects is nb [important] when transferring information' and 'to add 'non-verbal' is important as it encompasses all the for example seeing and smelling'. Participants felt that including all forms of communication in handovers will ensure holistic information transfer, 'more holistic approach by sharing all 3 methods of communication'.

5.2.3 | Attribute 3: Interprofessional processes

Theme 1: Interdisciplinary communication and collaboration

In round one, participants indicated that interprofessional processes requires communication and collaboration. During handover, different professionals meet and share information to ensure continuity of care. Participants agreed that 'information required for ongoing care' and 'patient care in the ED involves interprofessional collaboration and care practices'.

In rounds two and three, participants agreed that handover practices should be a person-centred interprofessional activity, 'interprofessional involvement is important', 'must work interprofessional to achieve person-centred care' and 'promotes interprofessional team approach which currently isn't really being implemented'. Furthermore, working interprofessionally requires that the right team be involved in the handover from the start, 'involving the right people from the start is in the best interests of the patient', 'interprofessional approach crucial to ensure nothing missed/overlooked' and 'all involved should be on the same page and get 1st hand information if possible'. Handing

TABLE 2 Summary of agreement and refined attributes after each round.

Attribute	Round 1 agreement	Refined attribute	Round 2 agreement	Refined attribute	Round 3 agreement	Final attributes
Structure	89%	Structured approach	100%	Context specific approach	89%	Context specific approach
Verbal and written information transfer	55.6%	Verbal and written information sharing	100%	Verbal, non-verbal and written information sharing	100%	Verbal, non-verbal and written information sharing
Inter-professional process	66.6%	Person-centred inter-professional activities	100%	Person-centred inter-professional activities	100%	Person-centred inter-professional activities
Inclusion of the patient and/or family	89%	Inclusion of the patient and/or significant other	88%	Inclusion of the patient and/or significant other	100%	Inclusion of the patient and/or significant other
Occurs at the bedside	77.8%	The dedicated space	88%	Dedicated space	100%	Dedicated space
Without interruptions	89%	Person-centred handover culture	100%	Person-centred handover culture	79%	Person-centred handover approach

over to the right team will reduce handover repetitions, 'multiple handovers have been associated with information loss'.

Theme 2: Interprofessional process requirements

This theme was similar for all three rounds. Participants agreed that the whole healthcare team should be present during handovers, 'it would be great if doctors and nurses could be present', 'often information given to the doctor and nurse is different…if they do not receive the handover together this information will be missing on the records of at least one of the practitioners', and 'the team specifically involves doctors and nurses–both parties should be included during handover practices'. This interprofessional process can also be influenced by several factors, 'values, language, and hierarchy' as well as 'interprofessional knowledge, interprofessional respect, and existing relationships and perceptions'. These factors may influence the interprofessional process and affect handover practices.

5.2.4 | Attribute 4: Inclusion of the patient and/or family

Theme 1: Patient inclusion is important

In round one, participants felt that patients and/or families should be included in handovers, since 'being person-centred means both knowing and respecting the preferences of the patient and their companions about their involvement in handover practices', 'the patient…the best source of information', and 'patient and family must be included–nothing about me without me'.

In rounds two and three, participants agreed that patients and/or family may contribute to making decisions and delivering care, 'the patient being part of the conversation that informs care delivery', 'the patient however has the right to be involved in their care, 'if patient is not able to be part of decision-making process, the family/significant other should be involved from the beginning', and 'it is about the patient being part of the conversation that informs care delivery'.

Participants agreed that patients and/or significant others play an important role in handovers. Patient participation promotes shared decision making. Patients and significant others can also provide valuable extra information, described as follows: 'shared-decision making', 'I have personally witnessed patients adding information to handovers that was not included, this highlights how important patient and [significant other] participation can be', and 'significant others play an vital role in supplementing information'.

Theme 2: Considering patient preferences

Participants indicated that patients should be given an option to be included or not, 'respecting the preferences of the patient' and 'the patient should have a choice whether to include the family or not–that is if they are able to'. Giving patients an option to choose is inherent in person-centred care.

5.2.5 | Attribute 5: Occurs at the bedside

Theme 1: Provides multiple opportunities

In round one, participants felt that handovers should occur at the bedside as there are multiple opportunities for information transfer. Healthcare professionals have to form first impressions, 'provides opportunity for visual check of the patient, environment, equipment, documents…is critical in an ED setting'. Handovers at the bedside give healthcare professionals an opportunity to verify patient-specific information, 'gives opportunity to look at the patient and verify the information received with what is observed at that stage' and '… would ensure that the handover is related to a specific patient'. Handovers at the bedside contribute to person-centred care, 'opportunity to include patient and family' and 'give the patient the opportunity to hear what was handed over and add missing info'.

Theme 2: Context specific

Participants felt that performing handovers at the bedside may also have some negative aspects and that the context of EDs should be considered, 'would depend on the context and layout of the ED. If it is not possible to do so without jeopardizing the patients privacy and limiting the interruptions, another area can be considered' and 'the bedside is sometimes the most noisy and busy area'.

In rounds two and three, this attribute was adjusted to include a dedicated space. Participants agreed that handovers should be performed in a dedicated space. This space is often at the bedside, but the context of the unit should be considered. The space should allow for effective communication, 'this makes the dedicated space-the bedside', 'it has to occur at the bedside to include the patient', 'the context rather than the space is more important' and 'dedicated area ensures that the right people accept the handover in an environment that is conducive to communication and effective handover'.

Participants indicated that effective handover spaces should have minimal interruptions and distractions. This is not always easy in busy ED environments. Conducting handovers by the patient's bedside can facilitate patient and/or significant other participation, reduce interruptions from bedside activities, and promote confidentiality and person-centred care, 'around the patient's bedside encourages patient and significant others' participation' and 'must have time and space to do an effective handover'.

5.2.6 | Attribute 6: No interruptions

Theme 1: Handover practices without interruptions

In round one, participants indicated that handovers should ideally be performed without interruptions, '…without interruptions is ideal and beneficial as there is no diversion of attention to other issues or aspects. The practitioner can focus solely on the information being provided to them'. Handovers are vital for transferring care and ensuring continuity, 'the handover should be seen as an almost sacred time and if all involved treat it with the respect and importance it deserves, it is the golden opportunity to hand over all important information. Once again this culture must be nurtured from both professions involved in this process side'.

Theme 2: Consequences of interruptions

According to participants, interrupted handovers have multiple disadvantages, 'the consequences of interruptions can be significant for both deliverer and receiver of handover', 'interruptions may lead to information being missed'. Healthcare practitioners should guard against interruptions.

Theme 3: Interruptions are unavoidable

Participants indicated that although interruptions should be avoided; interruptions are sometimes unavoidable and even necessary, 'the immediate or urgent care needs of the patient may (and should) take precedence over the transfer of care' and 'someone has essential information that needs to be shared'.

In rounds two and three, participants indicated that a person-centred handover culture will foster person-centred handover practices. Consequently, healthcare professionals will provide high-quality person-centred care and person-centred continuity of care, 'contribute to the development of person-centred care handover practices', 'person-centred handover is an critical component of person-centred continuity of care. When we keep the patient the centre of all we do, especially when handing over, we are able to transcend hierarchies, inter-professional issues and systematic barriers to effective patient care'.

Participants suggested that there should be one dedicated person to oversee handovers. This person might receive the handover from emergency care practitioners whilst other healthcare practitioners continue with patient care delivery, 'someone should be allocated to do the handover as a priority while other healthcare professionals continue care'.

5.3 | Concept definition

Table 3 provides a summary of the concept definition development over the three rounds.

5.3.1 | Round one

In round one, 89% of participants agreed with the proposed concept definition.

Participants stated that not all of the attributes were included in the definition, 'work on the flow of the definition', 'this is quite long, and I wonder if it could be more succinct' and 'the definition would benefit from stronger wording related to patient-centeredness'.

TABLE 3 Summary of agreement and adjusted definition after each round.

Concept definition	Agreement
Person-centred handover practices are those handovers being performed while including all identified defining attributes such as structure, verbal, and written information transfer, interprofessional process, inclusion of the patient and/or family, occurs at the bedside, without interruption	89%
Round one	
Person-centred handover practices are the interprofessional sharing of structured verbal and written information that happens in a dedicated space without interruptions allowing the patient and/or significant other to participate	86%
Round two and three	
Person-centred handover practices are a context specific approach involving the interprofessional sharing of verbal, non-verbal and written information that happens at the patient's bedside with minimal interruptions and facilitate patients and/or their significant others' active engagement	100%

5.3.2 | Round two

In round two, 86% of participants agreed with the adjusted definition. Although consensus was reached, participants made valuable suggestions to improve the definition.

Some participants (50%) indicated that all the important points were included in the definition, 'I think this captures the most important points succinctly'. The rest of the participants felt that some clarification was needed on the 'dedicated space' attribute and to include the component of visual communication, 'the concept dedicated space must be clarified' and 'you have also omitted visual communication'.

5.3.3 | Round three

In round three, all participants (100%) agreed with the adjusted definition. There were no additional comments and the adjusted definition was not changed, 'agreed, well-constructed and inclusive of attributes'.

6 | DISCUSSION

The study aimed to create a shared understanding of the concept of person-centred handover practices. Different definitions exist for handover, but the most accepted definition is the transfer of responsibility and accountability of care from one healthcare practitioner to the next (Sanjuan-Quiles et al., 2018). Person-centred care has also been described in different ways, with all definitions placing the patient at the centre of their care (McConnell et al., 2016). Here, we conducted a Delphi study to develop an accepted definition of person-centred handover practices as follows:

> Person-centred handover practices is a context specific approach involving the interprofessional sharing of verbal, non-verbal, and written information that occurs in an dedicated space at the patient's bedside with minimal interruptions and facilitate patients and/or their significant others' active engagement.

In EDs, handover practises are a high-risk activity requiring a meticulous approach to preventing patient harm (Bagnasco et al., 2019; Dúason et al., 2021; Ehlers et al., 2021; Jensen et al., 2013). The need for person-centred care delivery in EDs has also been cited many times (Almaze & de Beer, 2017; McConnell et al., 2016). Implementing person-centred handover practices are one way of initiating person-centred care in EDs.

Participants discussed various attributes of person-centred handover practices iEDs. The first attribute dealt with implementing a structured, context specific approach. Within the context of EDs, handovers should focus on patient needs to support the transfer of relevant information. During handovers, emergency care practitioners are responsible for informing healthcare professionals regarding prehospital problems and treatments, so that healthcare professionals can plan further treatment and ensure continuity of care. Many studies suggest that all relevant information such as problems, procedures, treatments and vital signs (Dúason et al., 2021; Flynn et al., 2017) be transferred using a specific structure. Different strategies, such as mnemonics, have been implemented in EDs to ensure structured transfer of information (Yegane et al., 2017). Participants highlighted that handovers are not a case of one size fits all and most mnemonics are not suitable for handovers in EDs (Hovenkamp et al., 2018; Makkink et al., 2019). In our definition, information should be shared in a manner that focuses on the needs of patients to support the transfer of relevant information.

The second attribute focusses on sharing verbal, non-verbal and written information during handover. During handovers, information should first be shared verbally followed by a written document. Talking ensures that first-hand, contextual information is received from emergency care practitioners. The information is then written down to record facts and ensure comprehensiveness. Healthcare practitioners can refer to written documents once emergency care

practitioners have left. Written records prevent information loss (Dúason et al., 2021) and can be used as a reference. Non-verbal information is also important as it ensures a more holistic approach when sharing all three types of communication (Crouch et al., 2021). Information about what emergency care professionals saw, smelt, experienced, and sensed about the patient and their environment is important for holistic patient care.

The third attribute identified person-centred interprofessional activities as an important attribute of person-centred handover. Handovers are an interprofessional activity, transferring accountability and responsibility, underpinned by person-centred principles that will ultimately affect patient care (Makkink et al., 2021). Ideally, the healthcare team responsible for patient care should be involved in handovers from the beginning to reduce the need for repeated handovers and reduce the risk of information loss. Handovers are an interprofessional process involving at least two different professional groups (Ehlers et al., 2021). When these professional groups with their own organisational cultures meet, cultures have to merge to ensure the transfer of responsibility and accountability (Jensen et al., 2013). Interprofessional collaboration is vital for achieving person-centred care.

The fourth attribute of person-centred handover practices includes the active involvement of patients and their significant others. Handover practises should be flexible and encourage participation of patients and significant others and provide an opportunity for shared decision making. Handovers that include patients and their significant others allows them to participate in their own care, state their complaints to guide care planning, and be part of decision-making (White-Trevino & Dearmon, 2018). Patients are the only constants during handovers and are vital for ensuring continuity of care (Merten et al., 2017).

The fifth attribute of person-centred handover practices involves having a dedicated space for handovers. Handovers should occur in a dedicated space preferably around the patient's bedside with minimal interruptions. The space should allow for effective communication whilst ensuring patient confidentiality. Handovers in EDs are different from handovers in other environments (Sanjuan-Quiles et al., 2018). EDs are complex environments and reliable communication is vital (White-Trevino & Dearmon, 2018), but EDs are characterised by constant interruptions (multi-tasking, workload) and distractions (alarms, noise and overcrowding) (Sanjuan-Quiles et al., 2018). Handovers often take place while multiple healthcare professionals interact with the patient at the same time (Sanjuan-Quiles et al., 2018). Constant interruptions during handovers may cause information loss and negatively impact patient care. Handovers that occur around the patient's bedside may be lead to fewer interruptions, reduce noise levels and provide an opportunity for healthcare professionals to listen attentively (Bost et al., 2012; Najafi Kalyani et al., 2017). This will also give the patient an opportunity to participate in their own care (Kullberg et al., 2017).

The sixth attribute states that handovers should be person-centred. Participants suggested that a dedicated healthcare professional should actively participate and facilitate the handover process to nurture a person-centred handover approach. One person should be in charge of the providing the handover, and one person should be responsible for receiving the handover (Bost et al., 2012; Dúason et al., 2021). A dedicated healthcare professional should lead the handover process and listen attentively while other members of the healthcare team begin with treatment. This dedicated person should communicate with and include patients and/or significant others from the start.

7 | LIMITATIONS AND STRENGTHS

Our panel comprised of experts in clinical and academic settings from different countries increasing the transferability of the attributes and definition into EDs globally. Our findings may be limited by small sample size.

8 | CONCLUSIONS

Having a shared definition and clearly defined attributes for person-centred handover practices is an important step towards improving handover practices in EDs. This definition may serve as a base for improving person-centred care in EDs. In the future, this shared definition can be used to develop clinical practice guidelines for person-centred handover practices in EDs.

9 | RELEVANCE TO CLINICAL PRACTICE

To date, this is the first shared definition for person-centred handover practices in EDs. Ideally, person-centred handovers will lead to person-centred care in EDs. Our findings have implications for education practice. The definition and related attributes can also be implemented in nursing, emergency care practitioner and healthcare professionals' curricula. This definition can also serve as a platform for further conceptual studies.

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CONFLICT OF INTEREST STATEMENT

The authors indicate no potential conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are openly available in University of Pretoria Research data at https://figshare.com/s/0923702aa9b0aa7fd1d5, reference number 10.25403/UPresearchdata.24310696.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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